Superior Eye

Health & Vision Therapy Center

2822 Venture Drive | Marquette, MI 49855 | phone: 906.228.4401 | fax: 906.225.0460 | info@superioreye.com

General Information

Patient's full name _____
Home phone number _____
Fax number _____
E-mail _____
Home address _____
City _____ State _____ Zip _____
Social Security Number _____
Age _____ Birthdate _____
Sex: M F Marital Status: S M D W
Employer _____
Address _____
City _____ State _____ Zip _____
Work phone number _____
If married, name of spouse _____
Primary Health Care Plan _____
_____
Policy number _____
Insured person _____
Insured Social Security Number _____
Emergency contact _____

Medical History

Date of injury _____
Explanation of Injury _____
_____
_____
_____
_____
Date of most recent medical exam _____
Name of physician _____
Date of last vision examination _____
Name of doctor _____
Results _____
_____

Head Trauma History

Please return this form so our staff may schedule appropriatley; or at least ONE WEEK prior to your appointment in the enclosed envelope. This assists Dr. Johnson in determining the visual performance tests needed.

Medications currently using _____
_____
_____
For what condition(s) _____
_____
_____

Please fill in any of the following professionals that you have seen related to your injury:

☐ Psychiatrist ☐ Psychologist ☐ Family Physician
☐ Neurologist ☐ Osteopath ☐ Speech Therapist
☐ Psychologist ☐ Chiropractor ☐ Physical Therapist
☐ Massage Therapist ☐ Neuropsychologist
☐ Opthalmologist ☐ Emergency Room Doctor
☐ Audiologist/Otolaryngologist ☐ Occupational Therapist
☐ Other _____

Names of above physicians:

1) _____
2) _____
3) _____
4) _____
5) _____

Any history of the following? (please fill in)

	You	Family
High blood pressure:	☐	☐
Strabismus:	☐	☐
Diabetes:	☐	☐
Thyroid Condition:	☐	☐
Blindness:	☐	☐
Multiple Sclerosis:	☐	☐
Brain Injury:	☐	☐
Stroke:	☐	☐
Amblyopia:	☐	☐
Brain Tumor:	☐	☐
Cataracts:	☐	☐
Glaucoma:	☐	☐

Do you experience the following? (please fill in)

	Yes	No
Brightness bothers you	☐	☐
Difficulty in stores or malls	☐	☐
Motion sickness	☐	☐
Head turns as reading across page	☐	☐
Eye ache	☐	☐
Losing place often when reading	☐	☐
Headaches	☐	☐
Using finger to keep place	☐	☐
Blurred vision	☐	☐
Short attention span for close work	☐	☐
Eye redness	☐	☐
Skipping words frequently when reading	☐	☐
Double Vision	☐	☐
Orient drawing poorly on page	☐	☐
One eye turns in or out	☐	☐
Squinting covering or closing one eye	☐	☐
Burning eyes	☐	☐
Tilting head during desk work	☐	☐
Eye drainage	☐	☐
Fatigues easily	☐	☐
Itching eyes	☐	☐
Holding books too closely	☐	☐
Delayed dressing skills	☐	☐
Avoid near tasks	☐	☐
Dislike heights	☐	☐
Difficulty following series of directions	☐	☐
Awkward, poor balance	☐	☐
Difficulty using both sides of body together	☐	☐
Patterned wallpapers/carpet bothersome	☐	☐
Movement of objects in the environment are bothersome	☐	☐

Motor Vehicle Accident

Type of vehicle you were in _____
Other vehicle(s) involved _____
Were you sitting in:
☐ Front Seat ☐ Back Seat ☐ Middle
☐ Left Side ☐ Right Side ☐ Unusual Position
Which restraints were used? (Check all that apply)
☐ Lap ☐ Shoulder ☐ Car Seat
☐ Booster Seat ☐ Air Bag
Speed of vehicle you were in _____
Speed of other vehicle or object _____
Did your vehicle hit another object?
☐ Yes ☐ No
Or did the other vehicle hit your vehicle?
☐ Yes ☐ No
If yes, where was your vehicle hit?
☐ Head on ☐ Toward Front ☐ Driver side
☐ Rear ended ☐ Toward rear ☐ Passenger side
Did you experience whiplash?
☐ Yes ☐ No
Did you hit your head?
☐ Yes ☐ No
If yes, on what _____
_____
_____
_____

I authorize the release of any medical information to process my insurance claim or the referral to another doctor, school or clinic; I also allow payment from insurance to be sent directly to Superior Eye Health and Vision Therapy Center.

Signed _____

Date _____